	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER 155697		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/03/2023	
	PROVIDER OR SUPPLIER	.ND SKILLED NURSING CENTEI	?	517 N L	ADDRESS, CITY, STATE, ZIP COD ITTLE LEAGUE BLVD SVILLE, IN 47129	•		
	<u> </u>		`		3VILLE, IN 47 129			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE	
E 0000	REGULATORT OR	LISC IDENTIFTING INFORMATION		TAG			DATE	
Bldg	An Emergency Prer	paredness Survey was	E 0	000				
		diana Department of Health in		000				
	Survey Date: 04/03/23							
	Facility Number: 0 Provider Number: 1002	155697						
	Rehab and Skilled N compliance with En Requirements for M	Preparedness survey, Clark Nursing Center was found in nergency Preparedness Iedicare and Medicaid Iers and Suppliers, 42 CFR						
	The facility has 83 of the survey, the cens	certified beds. At the time of us was 71.						
	Quality Review con	npleted on 04/11/23						
K 0000								
Bldg. 01	Licensure Survey w	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR	K 0	000				
	Survey Date: 04/03	7/23						
	Facility Number: 0 Provider Number: 1002	155697						
	At this Life Safety (	Code survey, Clark Rehab and						
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATUR	 Е	TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Holly Bricker **Executive Director** 04/28/2023

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155697		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  04/03/2023		
	REHABILITATION A	ND SKILLED NURSING CENTER		517 N L	DDRESS, CITY, STATE, ZIP COD ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	compliance with Re Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupa This one story facilit Type V (000) consts sprinklered. The fa with hard wired sme	atter was found not in requirements for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, eSC), Chapter 19, Existing ancies and 410 IAC 16.2. At was determined to be of ruction and was fully cility has a fire alarm system oke detectors in the corridors					
	operated smoke deterooms. The facility census of 71 at the t	dents have customary access d all areas providing facility clered.					
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting of than required encl exits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containir combustible mater hardware. Roller la CMS regulation. T	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in its grire for at least 20 fully sprinklered smoke only required to resist the experience. Corridor doors and doors					

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Event ID:

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Facility ID: 000059

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	01	COMPL	
		155697	B. WING			04/03/	2023
	PROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER	51	7 N LI	DDRESS, CITY, STATE, ZIP COD TTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE	CH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	G	DEFICIENCY)		DATE
TAG	flammable or com Clearance between covering is not excusive doors complying wif provided with a control the door closed with applied. There is closing of the door release when the permitted. Nonrate unlimited height at meeting 19.3.6.3.6 frames shall be lated other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies.  19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection rating devices, etc. Based on observation failed to ensure 1 of doors would close condoor frames. This control the devices is the service of the doors would close condoor frames. This control the doors would close condoor frames. This control the doors would close condoor frames. This control the doors include:	bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are ed protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are a sprinklered compartments ctions in area or fire is or frames in window  Parts 403, 418, 460, 482,  AS details of doors such as angs, automatics closing  on and interview, the facility of 45 resident room corridor completely and latch into their deficient practice could affect	K 0363		K-363 Based on observation, record review, and interview, the facil failed to ensure 1 of 45 resider room corridor doors would clos completely and latch into their door frames potentially affectir least 15 residents, staff and visitors.	nt se	04/10/2023
	p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director and Senior						
					What corrective action(s) wil	I	
	-	visor, the corridor door to			be accomplished for those		
		se completely and latch when			residents found to have been	1	
	tested several times	. The door was becoming			affected by the deficient		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155697	B. W	NG		04/03/	/2023
	PROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	I		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		f the door frame which would			practice?		
	not allow the door t	o close fully, leaving a two					
	inch gap between th	ne door and the frame along			· No residents, visitors or		
	the latching side. B	Based on interview at the time			staff were harmed or had a		
		Maintenance Director			negative outcome related to the	ne	
	acknowledged the c	corridor door to room 70 failed			alleged deficient practice. The	!	
		and latch into its door frame			door for room 70 was adjusted		
	when tested.  This finding was reviewed with the Maintenance Director and Senior Maintenance Supervisor during the exit conference.  3.1-19(b)				fully close completely and late	h	
					into the door frame.		
					How other residents having		
					the potential to be affected b	-	
					the same deficient practice v	vill	
					be identified and what		
					corrective action(s) will be		
					taken?		
					All regidents visitors on	. d	
					<ul> <li>All residents, visitors an staff could have the potential t</li> </ul>		
					affected by the alleged deficie		
					practice.	111	
					· Audit completed on all		
					facility corridor doors to ensure	e all	
					close completely and latch into		
					door frames.		
					Maintenance staff educ	ated	
					on corridor door requirements		
					fire safety per regulation.		
					What measure will be put int	0	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not occur?		
					Maintan ( % )	-41	
					Maintenance staff educ		
					on corridor door requirements	tor	
					fire safety per regulation.	r	
					Maintenance Director o  designee will complete the life		
	ī		1		r designee will complete the life		ī

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
		155697	B. W	ING		04/03/	2023
	PROVIDER OR SUPPLIE	R AND SKILLED NURSING CENTER		517 N L	ADDRESS, CITY, STATE, ZIP COD LITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Safety compliance audit of cor		(X5) COMPLETION DATE
					door closure requirements we times 4 weeks, monthly times months and semiannually thereafter to ensure complian	ekly 6	
					How the corrective action(s) will be monitored to ensure a deficient practice will not recur, ie., what quality assurance program will be p into place?	the	
					Maintenance Director of designee will complete Quality Control Environment Checklis Maintenance which includes corridor door closure/latches weekly times 4 weeks, monthit times 6 months and semiannuthereafter to ensure compliant The results of the audits will be reviewed monthly by the QAP committee overseen by Executive Changes for each deficiency will be completed April 10, 2023 Attachments A, B, C, D, E	y tt for ly ually ce. e I	
K 0372 SS=E Bldg. 01	Barrie	ilding Spaces - Smoke ilding Spaces - Smoke ion					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPLETED	
		155697	B. W	ING		04/03/2023	
	PROVIDER OR SUPPLIER		)	517 N L	ADDRESS, CITY, STATE, ZIP COD LITTLE LEAGUE BLVD (SVILLE, IN 47129		
CLARK	REHABILITATION A	AND SKILLED NURSING CENTER	·	CLARK			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X:	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DAT	Έ
		nall be constructed to a					
		tance rating per 8.5. Smoke					
	-	permitted to terminate at an					
	atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.  19.3.7.3, 8.6.7.1(1)  Describe any mechanical smoke control system in REMARKS.						
		on and interview, the facility	K 0	372	K-372	04/10/	2023
	failed to ensure 2 of 4 smoke barrier walls were				Based on observation and		
	protected to maintain the smoke resistance of the				interview, the facility failed to	_	
		C Section 19.3.7.5 requires			ensure 2 of 4 smoke barrier w		
		e constructed in accordance 3.5 and shall have a minimum ½			were protected to maintain the		
		ating. This deficient practice			smoke resistance of the smok		
		residents, as well as staff and			residents, as well as staff and	20	
	visitors.	residents, as well as stall and			visitors.		
					What corrective action(s) wil	ı	
	Findings include:				be accomplished for those		
	-				residents found to have been	1	
	Based on observation	ons on 04/03/23 between 1:00			affected by the deficient		
	p.m. and 3:00 p.m. the Maintenance Di	during a tour of the facility with			practice?		
		visor, the following was noted:			No residents, visitors or		
	_	er wall above the smoke barrier			staff were harmed or had a		
		MF Hall and center Nurses'			negative outcome related to the	ne	
		wo and a half inch gap around			alleged deficient practice. The		
		with a foam sleeve that was			barrier walls were repaired to		
	not properly fire sto				specifications required to ensu		
		er wall above the smoke barrier			protection and maintain the sr	noke	
		20 Hall and center Nurses'			resistance of the smoke barrie	r	
		oot by three foot opening cut			wall.		
	out of the wall.  Based on interview at the time of each						
					How other residents having		
		nintenance Director said the			the potential to be affected by	-	
	be fixed as soon as	ne smoke barrier walls would			the same deficient practice v	VIII	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155697	B. WI	NG		04/03/	/2023
				_			
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					LITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
					corrective action(s) will be		
	This finding was re	viewed with the Maintenance			taken?		
		r Maintenance Supervisor					
	during the exit conf	-			· All residents, visitors ar	ıd	
					staff could have the potential t		
	3.1-19(b)				affected by the alleged deficie		
					practice.	-	
					· Life safety compliance		
					audit on smoke barrier		
					penetrations. All smoke barrie	er	
					areas identified, inspected and		
					met the compliance requireme		
					of regulation.		
					Maintenance staff educ	ated	
					on life safety regulation related		
					appropriate sealing of smoke		
					barrier penetration.		
					· '		
					What measure will be put int	0	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not occur?		
					· Maintenance staff educ	ated	
					on life safety regulation related	d to	
					appropriate sealing of smoke		
					barrier penetration.		
					Maintenance Director o	r	
					designee will complete the life	<u>!</u>	
					safety compliance audit of sm		
					barrier penetrations weekly tin		
					4 weeks, monthly times 6 mor		
					and semiannually thereafter to		
					ensure compliance.		
					·		
					How the corrective action(s)		
					will be monitored to ensure t		
					deficient practice will not	-	

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recur, ie., what quality

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155697	B. WI	NG		04/03/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	R			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER		CLARKSVILLE, IN 47129			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					assurance program will be p into place?		
					· Maintenance Director o		
					designee will complete the life		
					safety compliance audit of sm		
					barrier penetrations weekly tin		
				4 weeks, monthly times 6 mor and semiannually thereafter to			
				ensure compliance. The result			
				the audits will be reviewed mo			
				by the QAPI committee overse	-		
				by the Executive Director.	,011		
				by the Excounte Birector.			
					By what date the systemic		
					changes for each deficiency		
					will be completed		
					April 10, 2023		
					Attachments F, G, H		
K 0511	NFPA 101						
SS=E	Utilities - Gas and	Electric					
Bldg. 01	Utilities - Gas and	Electric					
		gas or related gas piping					
	-	PA 54, National Fuel Gas					
		iring and equipment					
	•	PA 70, National Electric					
		stallations can continue in					
	service provided r						
	18.5.1.1, 19.5.1.1	t t					
		on and interview, the facility	K 0	511	K - 511 – Utilities – Gas and		04/10/2023
		f over 20 wet locations, were			Electric		
		nd fault circuit interrupter			Based on observations and		
		igainst electric shock. NFPA			interview, the facility failed to		
		ion at 210.8 Ground-Fault			ensure 1 of over 20 wet location		
	•	Protection for Personnel,			were provided with ground fau		
	_	circuit-interruption for			circuit interrupter (GFCI) prote	ction	
	•	provided as required in			against electric shock.		
		C). The ground-fault			What corrective action(s) wil	ı	
	_	hall be installed in a readily			be accomplished for those	_	
	accessible location.		1		residents found to have beer	1	I

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DEPARTMENT OF HEALTH AND HUMAN SERVIO	CES
CENTERS FOR MEDICARE & MEDICAID SERVIC	ES

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155697	A. BUILDING <u>01</u> C			(X3) DATE SURVEY COMPLETED 04/03/2023
	ROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER		517 N L	ADDRESS, CITY, STATE, ZIP COD ITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
		See 215.9 for ground-fault rotection for personnel on			affected by the deficient practice?	
	single-phase, 15- an	elling Units. All 125-volt, id 20-ampere receptacles tions specified in 210.8(B)(1) we ground-fault			<ul> <li>No residents, staff or visitors were affected by the alleged deficient practice.</li> </ul>	
	circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are				How other residents having the potential to be affected be the same deficient practice who identified and what corrective action(s) will be taken?	-
	not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable.  Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection.  (5) Sinks - where receptacles are installed within				All residents, staff and visitors could have the potentiabe affected by the alleged defipractice.	
					<ul> <li>A cover plate was instal over the electrical receptacle.</li> <li>Life safety audit tool for utilities, gas and electric regard GFCI receptacles completed vno new issues identified.</li> </ul>	ding
					<ul> <li>Maintenance director educated on GFCI requirement per regulations.</li> </ul>	
	Exception No. 1 to receptacles used to removal of power w	outside edge of the sink. (5): In industrial laboratories, supply equipment where rould introduce a greater nitted to be installed without			What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?	0
	Exception No. 2 to (patient bed location care areas of health covered under	(5): For receptacles located in s of general care or critical care facilities other than those protection shall not be required.			<ul> <li>Maintenance director</li> <li>educated on GFCI requirement</li> <li>per regulations.</li> <li>Maintenance director or</li> <li>designee will complete the life</li> </ul>	

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155697	B. WI	ING		04/03/	/2023
CLARK F	Г	ND SKILLED NURSING CENTER		517 N L CLARK	ADDRESS, CITY, STATE, ZIP COD LITTLE LEAGUE BLVD SVILLE, IN 47129	-	avc)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
TAG	(6) Indoor wet locat	LISC IDENTIFYING INFORMATION	+	TAG	safety compliance audit of GF	CI	DATE
	( )	rith associated showering			electrical receptacles weekly	Ci	
	facilities	The abbotiated showering			times 4 weeks, monthly times	6	
		e bays, and similar areas where			months and semiannually	Ü	
	electrical	• /			thereafter to ensure compliance	ce.	
	diagnostic equipme	nt, electrical hand tools.			· ·		
	NFPA 70, 517-20 V	Vet Locations, requires all					
	receptacles and fixe	ed equipment within the area of			How the corrective action(s)		
	the wet location to have ground-fault circuit				will be monitored to ensure t	the	
	interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure.				deficient practice will not		
					recur, ie., what quality		
					assurance program will be p	ut	
	This deficient practice could affect mostly kitchen staff.				into place?		
					The Maintenance Direc		
	Findings includes				or designee will be responsible		
	Findings include:				the completion of the life safet compliance audit of GFCI	ly	
	Based on observation	ons on 04/03/23 between 1:00			receptacles. The audits will be	,	
		during a tour of the facility with			completed weekly times 4 weekly		
	the Maintenance Di	- ·			monthly times 6 months and	ono,	
		visor, the electric receptacle			semiannually thereafter to ens	sure	
	_	he two compartment sink in the			compliance. The results of the		
		ed with a GFCI receptacle,			audits will be reviewed month		
	however, when test	ed with a GFCI testing device			the QAPI committee overseer	by	
	it indicated the rece	ptacle had an Open Ground			the Executive Director. Any a	reas	
		ne electrical circuit. Based on			noted to be non-compliant with	h the	
		e of observation, the			audits will be corrected.		
		for agreed the receptacle in the					
	kitchen was not pro	perly GFCI protected.					
	TE1 ' C' 1'	t dad set :			By what date the systemic		
	_	viewed with the Maintenance			changes for each deficiency		
	during the exit conf	Maintenance Supervisor			will be completed		
	during the exit conf	CICICC.			April 10, 2023 Attachments I, J, K		
	3.1-19(b)				/ maominomo i, J, M		
	17(0)						
K 0923	NFPA 101						
SS=E	Gas Equipment -	Cylinder and Container					
Bldg. 01	Storag		1				

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	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER  155697		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/03/2023	
NAME OF I	PROVIDER OR SUPPLIEI	R			DDRESS, CITY, STATE, ZIP COD	•		
					ITTLE LEAGUE BLVD			
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTE	R	CLARKS	SVILLE, IN 47129			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		Cylinder and Container						
	Storage							
		qual to 3,000 cubic feet						
	Storage locations are designed, constructed,							
		accordance with 5.1.3.3.2						
	and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an							
		in an enclosed interior						
	space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if							
		closed in a cabinet of						
		construction having a						
		ire protection rating.						
		al to 300 cubic feet						
	· · · · · · · · · · · · · · · · · · ·	compartment, individual						
	_	e for immediate use in						
	I -	s with an aggregate volume						
	-	ual to 300 cubic feet are not						
	-	red in an enclosure.						
	-	e handled with precautions						
	as specified in 11							
		ign readable from 5 feet is						
		ate of a cylinder storage						
	_	sign includes the wording as						
		TION: OXIDIZING GAS(ES)						
	STORED WITHIN	• • •						
	Storage is planne	d so cylinders are used in						
	order of which the	ey are received from the						
	supplier. Empty of	cylinders are segregated						
	from full cylinders	. When facility employs						
	cylinders with inte	egral pressure gauge, a						
	threshold pressur	e considered empty is						
	established. Emp	oty cylinders are marked to						
	avoid confusion.	Cylinders stored in the open						
	are protected fron	n weather.						
	11.3.1, 11.3.2, 11	.3.3, 11.3.4, 11.6.5 (NFPA						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRU			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		155697	A. BUILDING B. WING		01	COMPLETED 04/03/2023	
		100007	D. 111		_	0-1/00/2020	
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD LITTLE LEAGUE BLVD		
CLARK REHABILITATION AND SKILLED NURSING CENTER					(SVILLE, IN 47129		
			I	ID		(VE)	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	99)						
	Based on observation	Based on observation and interview, the facility		923	K – 923 Gas	04/10/2023	
	failed to ensure cylinders of nonflammable gases				Equipment-Cylinder and		
	such as oxygen were properly secured from falling				Container Storage		
	in 1 of 5 smoke compartments. NFPA 99, Health				Based on observation and		
		e, 2012 Edition, Section 11.3.3			interview, the facility failed to		
	states storage for nonflammable gases with a total				ensure cylinders of nonflamm	able	
	_	less than greater than 8.5 cubic			gases such as oxygen were		
	meters (300 cubic feet) shall comply with 11.3.3.1				properly secured from falling i	n 1	
	and 11.3.3.2. NFPA 99, Section 11.3.3.2 states				of 5 smoke compartments.		
	precautions in handling cylinders specified in				What corrective action(s) will	II	
		accordance with 11.6.2. Section			be accomplished for those		
		freestanding cylinders shall be			residents found to have been	n	
		supported in a proper cylinder			affected by the deficient		
		deficient practice could affect			practice?		
	over 20 residents, s	taff, and visitors.					
	F. 1				No residents, staff or		
	Findings include:				visitors were affected by the		
	D 1 1 04/02/221 1 00				alleged deficient practice.		
	Based on observations on 04/03/23 between 1:00				Llow other residents beginn		
	p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director and Senior		the potential to be affected		How other residents having	•	
	Maintenance Supervisor, there were two E size				the same deficient practice v	-	
	oxygen cylinders on the floor in the oxygen		be identified and what		I -	WIII	
	transfilling/storage room freestanding and were				corrective action(s) will be		
	not supported in a proper cylinder stand or				taken?		
		From falling. Based on					
	interview at the time of the observation, the				· All residents, staff and		
	Maintenance Director acknowledged the two E				visitors could have the potenti	al to	
	size oxygen cylinders freestanding on the floor				be affected by the alleged def	•	
	and not supported in a cylinder stand or				practice.		
	otherwise secured f				· A cylinder cage has bee	en	
		-			installed for all cylinders of		
	This finding was re	viewed with the Maintenance			nonflammable gases such as		
		Maintenance Supervisor			oxygen to be properly secured		
	during the exit conf				· Audit of nonflammable	•	
					cylinders such as oxygen stor	-	
	3.1-19(b)				indicated only 1 location with	all	
					secure in newly installed cylin	der	
					cage.		

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155697		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  04/03/2023		
	ROVIDER OR SUPPLIE	R AND SKILLED NURSING CENTE	517 N I	ADDRESS, CITY, STATE, ZIP COD LITTLE LEAGUE BLVD (SVILLE, IN 47129	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	TION (X5) ILD BE COMPLETION ROPRIATE DATE	
				<ul> <li>Nursing staff and Maintenance Director educ- the proper storage of nonflammable gas cylinders as oxygen in newly installed</li> </ul>	s such	
				What measure will be put place or what systemic changes will be made to ensure that the deficient practice does not occur?	into	
				Nursing staff and Maintenance Director educe the proper storage of nonflammable gas cylinders as oxygen in newly installed. Maintenance director designee will complete nonflammable gas cylinder storage audit daily times 4 weekly times 4 weeks, mon times 6 months and semiar thereafter to ensure compliant.	s such d cage. or weeks, thly unually	
				How the corrective actions will be monitored to ensur deficient practice will not recur, ie., what quality assurance program will be into place?  The Maintenance Dir or designee will be respons the completion of a modifier safety compliance audit of nonflammable gases cylind storage. The audits will be completed weekly times 4 versus and to ensure the completed weekly times 4 versus actions.	e the e put ector ible for d life er	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155697	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/03/2023			
NAME OF PROVIDER OR SUPPLIER  CLARK REHABILITATION AND SKILLED NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)		CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIAT	TE	(X5) COMPLETION DATE		
				semianr complian audits w the QAF the Executive	times 6 months and hually thereafter to ensince. The results of the vill be reviewed monthly PI committee overseen cutive Director. Any are be non-compliant with vill be corrected.	e y by by reas			
				changes will be of April 10,	t date the systemic s for each deficiency completed , 2023 nents L, M, N, O, P				

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